

---

## **Executive summary**

---

## Executive summary

---

Since its creation, the Medicare program has protected millions of beneficiaries from poverty by helping to pay for acute medical services. It has improved access to care for the elderly and many disabled Americans and is, by many technical and political measures, among the key policy successes of this century. Still, as the health care market evolves in this country, and as beneficiaries grow older and their health care needs change, Medicare must also evolve. In enacting the Balanced Budget Act of 1997 (BBA), the Congress took important steps to begin this evolution and to help extend the program's solvency in the short run. As the Secretary of Health and Human Services implements policies under this legislation, the Medicare Payment Advisory Commission (MedPAC) will monitor how well the program serves beneficiaries. Does it protect them from financial risk, while providing for care of adequate quality? Does it help them choose between insurance options and ensure access to needed services? And does it meet the special needs of vulnerable beneficiaries? In this volume, MedPAC begins to address these questions and offers recommendations to the Congress and the Secretary for improving the Medicare program.

### **Beneficiaries' financial liability and Medicare's effectiveness in reducing personal spending**

Medicare is by far the largest source of payment for beneficiaries' medical care services and a significant source of payment for beneficiaries with high medical costs. Although the program does a reasonably good job of reducing out-of-pocket spending on medical care, some beneficiaries still face high personal spending because of the program's cost-sharing requirements; its lack of an annual limit on out-of-pocket spending; and its poor coverage of some services, such as medical equipment and supplies. Beneficiaries in long-term care facilities, and those who are female or age 85 or older face the highest total risk, while low-income beneficiaries are most likely to spend large fractions of their income on medical services.

### **Influencing quality in traditional Medicare**

In addition to monitoring beneficiaries' exposure to financial risk, policymakers need to look closely at Medicare's systems for ensuring health care quality for beneficiaries who obtain care under all types of health care financing and delivery arrangements. In Medicare, as in the private sector, the strategies, techniques, and activities for safeguarding and improving quality have evolved differently under indemnity insurance and managed care. Because of historical objectives, structural limitations, and legislative restrictions, fewer (and different) approaches are now used under traditional Medicare, as compared to the program's managed care option, known as Medicare+Choice.

MedPAC identified actions needed to promote consistency and innovation in Medicare's quality initiatives. The Secretary should define programwide goals for improving Medicare beneficiaries' care and ensure that systems for monitoring, safeguarding, and improving the quality of care are, to the extent possible, comparable under traditional Medicare and Medicare+Choice. She should also work with interested parties to promote the development and use of common, core sets of quality measures that represent the full spectrum of beneficiaries' health care.

Other steps would maximize opportunities for reaching quality improvement goals in traditional Medicare. The Secretary should ensure that Medicare's quality assurance and improvement systems are consistent with best practices used by private health plans and purchasers. The Congress should provide the Health Care Financing Administration

(HCFA) with demonstration authority to test various mechanisms—such as payment incentives, preferred provider designations, or reduced administrative oversight—for rewarding health care organizations and providers that exceed quality and performance goals. Finally, the Secretary should develop and disseminate consumer-oriented information on quality of care to help beneficiaries compare enrollment options and providers.

### **Addressing health care errors under Medicare**

Minimizing preventable errors must be a critical part of any effort to safeguard the quality of health care in both traditional Medicare and Medicare+Choice. Errors contribute to unnecessary patient injuries and health system costs; however, the experience of other industries has shown that errors can be reduced by changing the focus from individuals to systems and processes and by creating an environment in which errors are seen as opportunities for learning rather than reasons for punishment.

MedPAC recommends that Medicare establish patient safety as a quality improvement priority and take steps to reduce errors in beneficiaries' care. In pursuing safety improvements, the Secretary should consider opportunities for minimizing preventable errors through coverage and payment policies, quality measurement initiatives, and quality improvement programs. She should also support and use ongoing public and private error-reduction initiatives, including those to promote incident reporting by providers, to analyze root causes and patterns in occurrence, and to disseminate information designed to prevent recurrence.

Information on errors in delivering health care must be collected and analyzed if providers are to learn from errors and take steps to prevent recurrence. However, as long as providers fear the information they disclose can be used against them in a punitive manner, reporting preventable errors is unlikely to become routine practice. The Congress should address this fear by enacting legislation to protect the confidentiality of individually identifiable information relating to errors in health care delivery when that information is reported for quality improvement purposes.

Additional work is needed to determine the most effective ways for Medicare to minimize health care errors. MedPAC therefore recommends that the Secretary work with providers and other interested parties to identify and promote effective and efficient processes, structures, and activities for reducing preventable errors. The Secretary should not establish requirements that specify maximum tolerance rates of errors in health care delivery under Medicare's conditions of participation for health care providers but should instead set progressive targets for improving patient safety through Medicare's quality improvement programs. Additionally, she should fund research to study the appropriate use of autopsy, a procedure that can aid in uncovering and learning from errors, and evaluate approaches for using information from autopsies in quality improvement and error-reduction initiatives.

### **Structuring informed beneficiary choice**

Medicare beneficiaries have been a largely untapped resource for quality improvement in Medicare. Helping them make informed choices from the available alternatives would allow them to spend their health care dollars wisely. It would also supplement Medicare's efforts to improve quality. In the first year of the Medicare+Choice program, HCFA began to meet its congressionally mandated responsibilities to educate and inform Medicare beneficiaries about their insurance options. Although the first nationwide information campaign has yet to begin, early evidence suggests that the campaign faces many challenges, including beneficiaries' lack of familiarity with and poor understanding of core concepts, problems with beneficiaries' use of detailed

written materials, and confusion resulting from misinformation and the lack of coordination among information providers.

HCFA must modify its initiatives to address these challenges and to incorporate its growing understanding of beneficiaries' information needs and ways to address them. To help the agency do so, the Congress should give HCFA more flexibility to develop and disseminate appropriate consumer information materials, and it should fund HCFA's education initiatives directly and adequately through the appropriations process, rather than through assessing user fees on Medicare+Choice organizations.

To help make information more useful and accessible, the Secretary should develop and evaluate interactive tools that help beneficiaries process information and that give them a framework for understanding their choices. She should define and regularly update standard terms for describing Medicare coverage options, use these terms in informational materials, and promote use of the terms by Medicare+Choice organizations and others who provide beneficiaries with information on insurance options.

To assess whether beneficiaries' information needs are met, the Secretary should study enrollment patterns, paying particular attention to vulnerable groups. To protect beneficiaries—especially those who are frail or functionally illiterate—from misinformation, she should watch for aggressive marketing techniques or abuses.

### **Managed care for frail Medicare beneficiaries: payment methods and program standards**

A separate issue facing the Secretary is how to establish special managed care programs—such as the Program of All-Inclusive Care for the Elderly and the Social Health Maintenance Organization and EverCare demonstrations—as choices under Medicare. Decisions about payment methods and program standards will determine the future viability of these programs and whether they compete fairly with other managed care programs. Considering payment and standards for these special programs also raises broader issues of meeting the needs of frail Medicare beneficiaries in Medicare+Choice.

Because the planned risk adjustment method for Medicare+Choice does not appear to predict adequately the cost of care for frail beneficiaries, the Secretary should delay applying it to programs that specialize in caring for this population until alternatives are developed that would pay for their care appropriately. In the long term, the Secretary should set capitation payments for frail beneficiaries based on their personal characteristics, as opposed to setting rates based on the type of plan. Until then, she should study factors affecting the costs of care for all Medicare beneficiaries to determine what changes are needed to improve risk adjustment for frail beneficiaries; she should identify data needed to support improvements in the Medicare+Choice risk adjustment system; and she should evaluate partial capitation—a method of blending capitation and fee-for-service payments—to pay for the care of frail beneficiaries in Medicare+Choice and specialized plans.

To protect vulnerable beneficiaries, Medicare should carefully consider program standards in both Medicare+Choice and special programs for the frail elderly. In her quality measurement and reporting requirements for Medicare+Choice plans, the Secretary should include special measures for evaluating and monitoring care for frail beneficiaries. When applying program standards developed for Medicare+Choice to special programs for frail beneficiaries, Medicare should carefully consider each standard and its relevance for beneficiaries who enroll in special programs. Performance measures for special programs should reflect the needs of frail beneficiaries and the special practices to care for them.

## **Access to home health services**

Medicare pays for many frail beneficiaries to receive care at home, although advocates for beneficiaries and representatives of the home health industry contend that payment changes made under the Balanced Budget Act of 1997 have improperly restricted access to home health care. Preliminary data suggest that fewer Medicare beneficiaries receive home health care than in the recent past, that those using care receive fewer visits, and that the number of Medicare-certified home health agencies has decreased since the BBA was implemented. Some agencies report they no longer accept or are likely to discharge certain types of patients, and beneficiary representatives indicate that some beneficiaries have difficulty obtaining services to which they believe they are entitled under law. The degree to which these changes may be attributed to new payments enacted in the BBA is not clear, however. Concurrent policy changes, including antifraud initiatives and removing venipuncture as a qualifying service for home health benefits, and other factors in the home health market may also be important. Moreover, the lack of clinically based standards for home health use makes it impossible to assess whether these changes are appropriate or harmful.

To help ensure that beneficiaries have access to needed home health care, the Secretary should use criteria based on their clinical characteristics to monitor use of home health services. She should develop regulations, also based on clinical characteristics, that outline home health care coverage and eligibility, and establish a uniform process for ensuring that fiscal intermediaries have the training and ability to provide timely and accurate information about coverage and payment to home health agencies. Additionally, the Secretary should improve the Medicare appeals process for home health users and establish a mechanism for informing beneficiaries about their rights to appeal.

If the Congress is not confident that the Secretary can implement a prospective payment system for home health services by 2000, then it should explore the feasibility of establishing a budget-neutral process for agencies to exclude a small share of their patients from the BBA's aggregate per-beneficiary limits. This change would help ensure that vulnerable beneficiaries continue to have access to needed home health services.

## **Improving care at the end of life**

Another vulnerable population is the nearly 2 million Medicare beneficiaries who die each year. Too many of their physical, emotional, and other needs go unmet, although good care could minimize or eliminate this unnecessary suffering. Even hospices—which pioneered care for the dying—help only a small fraction of patients and are often used far later than they should be. MedPAC joins many others in finding the present situation unacceptable. Ensuring that beneficiaries receive humane, appropriate care at the end of their lives should be a priority for the Medicare program.

To help achieve this goal, the Secretary should make end-of-life care a national quality improvement priority for Medicare+Choice and traditional Medicare. She should promote advance care planning by practitioners and patients well before terminal health crises occur, support research on care at the end of life, sponsor projects to develop and test measures of the quality of end-of-life care for Medicare beneficiaries, and enlist quality improvement organizations (also known as peer review organizations) and Medicare+Choice plans to implement quality improvement programs for care at the end of life.

In addition, the Secretary should work with nongovernmental organizations as they educate the health care profession and the public about care at the end of life, and as they develop measures to accredit health care organizations and provide public accountability for the quality of end-of-life care.

## **Improving the quality of care for beneficiaries with end-stage renal disease**

Medicare policies also affect the quality of care for beneficiaries with end-stage renal disease (ESRD). Although survival and some clinical outcomes have improved for ESRD patients over the past five years, policy changes to permit higher doses of dialysis and appropriate clinical use of nutritional supplements could further improvement. For this reason, MedPAC recommends that the Secretary of Health and Human Services improve the quality of dialysis care by developing clinical criteria that could be used to modify payments for dialysis, covering nutritional therapy for malnourished ESRD patients as a renal benefit, and considering the quality assessment and assurance efforts of renal organizations.

With respect to payment, MedPAC reiterates its recent recommendation calling for an increase in the composite rate. The payment rate for dialysis has not increased since 1991, and the Commission is concerned about how this may affect the quality of care for dialysis patients.

To improve dialysis adequacy, the Secretary should determine clinical criteria for dialysis patients to receive increased frequency or duration of dialysis. Then she should examine the feasibility of a multitiered composite rate that would allow different payments based on the frequency and duration of dialysis prescribed, as well as other factors related to adequacy of dialysis.

Medicare does not cover nutrition supplements to treat the malnutrition that is a frequent complication of end-stage renal disease. To address this lack of coverage, the Secretary should determine clinical criteria for ESRD patients to be eligible for oral, enteral, or parenteral nutritional supplements. Coverage for these supplements should then be provided to eligible ESRD patients as a renal benefit apart from the composite rate. ■